



Facility Name & ID Number HALSTED TERRACE NSG CTR INC.

# 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	45,160	2,396	4,354	51,910	8
9	SNF/PED					9
10	ICF	47,031	1,057	58	48,146	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	92,191	3,453	4,412	100,056	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.38%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?  
1,906 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 05/01/76

J. Was the facility purchased or leased after January 1, 1978?  
YES ☐ Date                      NO ☒

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 64 and days of care provided 3,779

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	273,093	30,840	11,620	315,553		315,553	4,552	320,105			1
2	Food Purchase		431,466		431,466	(31,317)	400,149	(148)	400,001			2
3	Housekeeping	298,803	72,174		370,977		370,977	14,531	385,508			3
4	Laundry	67,106	46,197		113,303		113,303		113,303			4
5	Heat and Other Utilities			183,591	183,591		183,591	4,034	187,625			5
6	Maintenance	88,880	5,712	139,615	234,207		234,207	(15,637)	218,570			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	727,882	586,389	334,826	1,649,097	(31,317)	1,617,780	7,332	1,625,112			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,362,430	321,183	17,656	3,701,269		3,701,269	(16,597)	3,684,672			10
10a	Therapy	136,190		457	136,647		136,647		136,647			10a
11	Activities	180,784	9,765	2,400	192,949		192,949		192,949			11
12	Social Services	148,885		4,428	153,313		153,313		153,313			12
13	Nurse Aide Training											13
14	Program Transportation			455	455		455		455			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	3,828,289	330,948	49,396	4,208,633		4,208,633	(16,597)	4,192,036			16
	<b>C. General Administration</b>											
17	Administrative	473,007		608,932	1,081,939		1,081,939	(465,162)	616,777			17
18	Directors Fees											18
19	Professional Services			577,977	577,977		577,977	(428,713)	149,264			19
20	Dues, Fees, Subscriptions & Promotions			183,547	183,547		183,547	(150,826)	32,721			20
21	Clerical & General Office Expenses	192,292	3,600	216,843	412,735		412,735	81,759	494,494			21
22	Employee Benefits & Payroll Taxes			830,560	830,560	31,317	861,877	(21,597)	840,280			22
23	Inservice Training & Education			567	567		567		567			23
24	Travel and Seminar			4,782	4,782		4,782	(933)	3,849			24
25	Other Admin. Staff Transportation			1,878	1,878		1,878		1,878			25
26	Insurance-Prop.Liab.Malpractice			333,459	333,459		333,459	991	334,450			26
27	Other (specify):*							84,486	84,486			27
28	<b>TOTAL General Administration</b>	665,299	3,600	2,758,545	3,427,444	31,317	3,458,761	(899,995)	2,558,766			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,221,470	920,937	3,142,767	9,285,174		9,285,174	(909,260)	8,375,914			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			87,799	87,799		87,799	205,587	293,386			30
31	Amortization of Pre-Op. & Org.							10,583	10,583			31
32	Interest			165,108	165,108		165,108	599,773	764,881			32
33	Real Estate Taxes							279,196	279,196			33
34	Rent-Facility & Grounds			1,316,643	1,316,643		1,316,643	(1,314,000)	2,643			34
35	Rent-Equipment & Vehicles			41,903	41,903		41,903	(22,481)	19,422			35
36	Other (specify):*							40,769	40,769			36
37	TOTAL Ownership			1,611,453	1,611,453		1,611,453	(200,573)	1,410,880			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	123,912	155,681	7,571	287,164		287,164		287,164			39
40	Barber and Beauty Shops			767	767		767		767			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*	124,116			124,116		124,116	(124,116)				43
44	TOTAL Special Cost Centers	248,028	155,681	172,588	576,297		576,297	(124,116)	452,181			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,469,498	1,076,618	4,926,808	11,472,924		11,472,924	(1,233,949)	10,238,975			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(23,274)	30		9
10	Interest and Other Investment Income	(26,353)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(148)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,135)	21		18
19	Entertainment				19
20	Contributions	(34,753)	20		20
21	Owner or Key-Man Insurance	(21,597)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(136,411)	21		24
25	Fund Raising, Advertising and Promotional	(119,524)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,300)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,955)	20		28
29	Other-Attach Schedule	(270,950)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (645,400)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(588,549)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (588,549)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (1,233,949)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
HAI STED TERRACE NGC CTR INC.		
100	0020042	
Report Period Beginning:	01/01/02	
Ending:	12/31/02	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Franchise Tax	(467)	21 1
2 Equipment Rental	(8,152)	25 2
3 Non-allowable Lease Expense	(19,631)	25 2
4 Bank Service Charges	(2,270)	21 4
5 Write-Offs	(8,776)	21 5
6 Capitalized R&M	(20,903)	06 6
7 Veterans Pharmacy	(15,925)	10 7
8 Wage Assignment Fees	(672)	10 8
9 Fines	(41)	20 9
10 Prior Period Legal Fees	(1,370)	19 10
11 Out of State Seminar	(1,832)	24 11
12 Management Fees	(60,000)	17 12
13 Marketing Salary	(5,813)	43 13
14 Non-allowable salary	(20,000)	43 14
15 Bldg Company State Replacement Tax	(2,609)	21 15
16 Bldg Company Audit Fees	(4,905)	19 16
17 Marketing Salary	(98,363)	43 17
18		18
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98		98
99		99
100		100
101 Total	(270,950)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HALSTED TERRACE NSG CTR INC.

# 0020842

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			4,552									4,552	1
2	Food Purchase	(148)											(148)	2
3	Housekeeping			14,531									14,531	3
4	Laundry													4
5	Heat and Other Utilities			4,034									4,034	5
6	Maintenance	(20,903)		5,266									(15,637)	6
7	Other (specify):*													7
8	TOTAL General Services	(21,051)		28,383									7,332	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(16,597)											(16,597)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(16,597)											(16,597)	16
	C. General Administration													
17	Administrative	(60,000)			(26,601)	(204,283)	(174,278)						(465,162)	17
18	Directors Fees													18
19	Professional Services	(6,275)	4,905	(432,921)	1,551	4,027							(428,713)	19
20	Fees, Subscriptions & Promotions	(157,273)		603	5,844								(150,826)	20
21	Clerical & General Office Expenses	(160,048)	3,054	229,422	3,845	5,420	66						81,759	21
22	Employee Benefits & Payroll Taxes	(21,597)											(21,597)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,033)		63	37								(933)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			991									991	26
27	Other (specify):*			70,134	8,656	5,429	267						84,486	27
28	TOTAL General Administration	(406,226)	7,959	(131,708)	(6,668)	(189,407)	(173,945)						(899,995)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(443,874)	7,959	(103,325)	(6,668)	(189,407)	(173,945)						(909,260)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number      HALSTED TERRACE NSG CTR INC.      #      0020842      Report Period Beginning:      01/01/02      Ending:      12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(23,274)	208,206	20,655									205,587	30
31	Amortization of Pre-Op. & Org.		10,129	454									10,583	31
32	Interest	(26,353)	599,289	26,837									599,773	32
33	Real Estate Taxes		270,426	8,770									279,196	33
34	Rent-Facility & Grounds		(1,314,000)										(1,314,000)	34
35	Rent-Equipment & Vehicles	(27,783)		5,302									(22,481)	35
36	Other (specify):*		40,769										40,769	36
37	TOTAL Ownership	(77,410)	(185,181)	62,018									(200,573)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(124,116)											(124,116)	43
44	TOTAL Special Cost Centers	(124,116)											(124,116)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(645,400)	(177,222)	(41,307)	(6,668)	(189,407)	(173,945)						(1,233,949)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Halsted Associates		Bldg Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.      ☒ YES      ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,314,000	Halsted Terrace Associates	100.00%	\$	\$ (1,314,000)	1
2	V	32	Interest Income	12,289	Halsted Terrace Associates	100.00%		(12,289)	2
3	V	21	Administrative		Halsted Terrace Associates	100.00%	365	365	3
4	V	19	Audit		Halsted Terrace Associates	100.00%	4,905	4,905	4
5	V	31	Amortization		Halsted Terrace Associates	100.00%	10,129	10,129	5
6	V	33	Real Estate Taxes		Halsted Terrace Associates	100.00%	270,426	270,426	6
7	V	32	Mortgage Interest		Halsted Terrace Associates	100.00%	611,578	611,578	7
8	V	36	Mortgage Insurance		Halsted Terrace Associates	100.00%	40,769	40,769	8
9	V	30	Depreciation		Halsted Terrace Associates	100.00%	208,206	208,206	9
10	V	21	State Replacement Tax		Halsted Terrace Associates	100.00%	2,689	2,689	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,326,289			\$ 1,149,067	\$ * (177,222)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	ITEX CO./A.K. CARE	100.00%	\$ 4,552	\$ 4,552	15
16	V	3	HOUSEKEEPING				14,531	14,531	16
17	V	5	UTILITIES				4,034	4,034	17
18	V	6	REPAIRS AND MAINT.				5,266	5,266	18
19	V	19	PROFESSIONAL FEES				7,479	7,479	19
20	V	20	FEES, SUBSCRIPTIONS				603	603	20
21	V	21	CLERICAL AND GENERAL				28,889	28,889	21
22	V	24	EDUCATION/SEMINARS				63	63	22
23	V	26	INSURANCE				991	991	23
24	V	27	EMPLOYEE BENEFITS				554	554	24
25	V	30	DEPRECIATION				20,655	20,655	25
26	V	31	AMORTIZATION				454	454	26
27	V	32	INTEREST				26,837	26,837	27
28	V	33	REAL ESTATE TAXES				8,770	8,770	28
29	V	35	EQUIPMENT RENTAL				5,302	5,302	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES				200,533	200,533	32
33	V	27	GEN ADMIN. - EMP. BEN.				69,580	69,580	33
34	V								34
35	V	19	BOOKKEEPING SERVICES	440,400				(440,400)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 440,400			\$ 399,093	\$ * (41,307)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 36,831	\$ 36,831	15
16	V	19	PROFESSIONAL FEES				1,551	1,551	16
17	V	20	FEES, SUBSCRIPTIONS				5,844	5,844	17
18	V	21	CLERICAL AND GENERAL				3,845	3,845	18
19	V	24	SEMINARS				37	37	19
20	V	27	GEN ADMIN.- EMP. BEN.				8,656	8,656	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	63,432				(63,432)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 63,432			\$ 56,764	\$ * (6,668)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 101,217	\$ 101,217	15
16	V	19	PROFESSIONAL FEES				4,027	4,027	16
17	V	21	OFFICE				5,420	5,420	17
18	V	27	PAYROLL TAXES				5,429	5,429	18
19	V								19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEES	305,500				(305,500)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 305,500			\$ 116,093	\$ * (189,407)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 5,722	\$ 5,722	15
16	V	21	OFFICE				66	66	16
17	V	27	PAYROLL TAXES				267	267	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	180,000				(180,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 180,000			\$ 6,055	\$ * (173,945)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	President	Management	83.33%	See Attached	31	47.69%	Salary	\$ 182,727	17-01	1
2	Bernard Hollander	President	Management	83.33%	See Attached	31	47.69%	Alloc Salary	101,217	17-07	2
3	Jack Rajchenbach	Vice President	Management	10.00%	See Attached	2	3.08%	Alloc Salary	5,722	17-07	3
4	Mark Hollander	Relative	Executive	0	See Attached	25	41.67%	Salary	171,057	17-01	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 460,723		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number     HALSTED TERRACE NSG CTR INC.     #   0020842   Report Period Beginning:     01/01/02     Ending:   12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)     YES ☒     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization     ITEX COMPANY/A.K. CARE  
Street Address     6633 N. LINCOLN AVE.  
City / State / Zip Code     LINCOLNWOOD, IL. 60712  
Phone Number     ( 847) 679-9141  
Fax Number     ( 847) 679-1820

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	463,355	5	\$ 19,263	\$	109,500	\$ 4,552	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	463,355	5	61,490		109,500	14,531	2
3	5	UTILITIES	AVAILABLE BED DAYS	463,355	5	17,069		109,500	4,034	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	463,355	5	22,282		109,500	5,266	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	463,355	5	31,647		109,500	7,479	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	463,355	5	2,553		109,500	603	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	463,355	5	122,246		109,500	28,889	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	463,355	5	266		109,500	63	8
9	26	INSURANCE	AVAILABLE BED DAYS	463,355	5	4,194		109,500	991	9
10	27	EMPLOYEE BENEFITS	AVAILABLE BED DAYS	463,355	5	2,344		109,500	554	10
11	30	DEPRECIATION	AVAILABLE BED DAYS	463,355	5	87,403		109,500	20,655	11
12	31	AMORTIZATION	AVAILABLE BED DAYS	463,355	5	1,921		109,500	454	12
13	32	INTEREST	AVAILABLE BED DAYS	463,355	5	113,562		109,500	26,837	13
14	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	463,355	5	37,112		109,500	8,770	14
15	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	463,355	5	22,434		109,500	5,302	15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		5	771,563	771,563		200,533	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	267,713			69,580	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,585,062	\$ 771,563		\$ 399,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization CAREPATH HEALTH NETWORK  
Street Address 6633 N LINCOLN AVENUE  
City / State / Zip Code LINCOLNWOOD, IL 60712  
Phone Number ( 888) 707-6700  
Fax Number ( 847) 679-2150

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	617,442	13	\$ 358,512	\$ 358,512	63,432	\$ 36,831	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	617,442	13	15,097		63,432	1,551	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	617,442	13	56,887		63,432	5,844	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	617,442	13	37,424		63,432	3,845	4
5	24	SEMINARS	CARE PATH FEES	617,442	13	365		63,432	37	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	617,442	13	84,255		63,432	8,656	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 552,540	\$ 358,512		\$ 56,764	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization SHAYMARK MANAGEMENT CORP.  
Street Address 6633 NORTH LINCOLN  
City / State / Zip Code LINCOLNWOOD, IL. 60712  
Phone Number ( 847) 679-9141  
Fax Number ( 847) 679-1820

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	BERNIE HOLLANDER-SAL.	AVG. HRS WORKED	48	5	\$ 156,722	\$ 156,722	31	\$ 101,217	1
2	19	PROFESSIONAL FEES	AVG. HRS WORKED	48	5	6,235		31	4,027	2
3	21	OFFICE	AVG. HRS WORKED	48	5	8,392	8,392	31	5,420	3
4	27	PAYROLL TAXES	AVG. HRS WORKED	48	5	8,406		31	5,429	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 179,755	\$ 165,114		\$ 116,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization JLR MANAGEMENT CORP.  
Street Address 6633 NORTH LINCOLN  
City / State / Zip Code LINCOLNWOOD, IL. 60712  
Phone Number ( 847) 679-9141  
Fax Number ( 847) 679-1820

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HRS WORKED	59	9	\$ 168,808	\$ 168,808	2	\$ 5,722	1
2	21	OFFICE	AVG. HRS WORKED	59	9	1,932		2	66	2
3	27	PAYROLL TAXES	AVG. HRS WORKED	59	9	7,887		2	267	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HRS WORKED	40	1	36,296				7
8										8
9										9
10										10
11	21	SECRETARIAL	AVG. HRS WORKED	40	1	5,000				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 219,923	\$ 168,808		\$ 6,055	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HALSTED TERRACE NSG CTR INC. # 0020842 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**Ending: 12/31/02****SEE ACCOUNTANTS' COMPILATION REPORT**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Chase Automobile Finance		X	Automobile - Lexus	\$1,343.00	09/21/01	\$ 48,346	\$ 25,173	08/21/04	7.50%	\$ 2,450	1	
2	Mid-America Elevator		X	Elevator	\$2,998.00	05/24/99	148,200	39,969	05/24/04	7.90%	4,520	2	
3	ABB Business Finance		X	Paging System	\$541.00	07/01/01	25,393	19,068	06/01/06	10.13%	2,171	3	
4	First Mortgage		X	Mortgage			8,746,500	8,110,016			611,578	4	
5												5	
	Working Capital												
6	American National Bank		X	Line of Credit	Various			2,000,000		4.75%	79,719	6	
7	Shareholder Loan	X		Working Capital				696,539			75,352	7	
8												8	
9	TOTAL Facility Related				\$4,882.00		\$ 8,968,439	\$ 10,890,765			\$ 775,790	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule										(10,909)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (10,909)	14	
15	TOTALS (line 9+line14)						\$ 8,968,439	\$ 10,890,765			\$ 764,881	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 40,769 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
 (See instructions.)
 SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
 (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	A.I. CREDIT		X				\$				\$ 865	1
2	HILL-ROM		X								11	2
3	THE HARTFORD		X								20	3
4	INTEREST INCOME										(26,353)	4
5	ITEX CO./A.K. CARE	X									26,837	5
6	ITEX CO./A.K. CARE	X		INTEREST INCOME							(12,289)	6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	\$			\$ (10,909)	21

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$	269,493	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	272,145	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	2,652	3	
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	276,544	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	279,196	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1997	280,557	8		
	1998	285,569	9		
	1999	283,668	10		
	2000	256,659	11		
	2001	263,375	12		
<b>ACCRUAL = 2001 TAX x 1.05</b>					
<b>263,375 x 1.05 = 276,544</b>					
<b>ALLOCATED FROM ITEX CO./A.K. CARE - \$8,770</b>					

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

HALSTED TERRACE NSG CTR INC.

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0020842

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>25-16-316-001-000</u>	<u>Long Term Care Property</u>	\$ <u>26,101.45</u>	\$ <u>26,101.45</u>
2. <u>25-16-316-002-000</u>	<u>Long Term Care Property</u>	\$ <u>25,059.00</u>	\$ <u>25,059.00</u>
3. <u>25-16-332-012-000</u>	<u>Long Term Care Property</u>	\$ <u>85,914.94</u>	\$ <u>85,914.94</u>
4. <u>25-16-332-013-000</u>	<u>Long Term Care Property</u>	\$ <u>126,299.85</u>	\$ <u>126,299.85</u>
5. _____	_____	\$ _____	\$ _____
6. <u>10-35-312-022</u>	<u>Home Office</u>	\$ <u>37,582.47</u>	\$ <u>8,881.49</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>300,957.71</u>	\$ <u>272,256.73</u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    X \_\_\_\_\_ YES    \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

HALSTED TERRACE NSG CTR INC.

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0020842

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( )

FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      YES      NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,068

B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 3

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: 354,499 2. Number of Years Over Which it is Being Amortized: 25

3. Current Period Amortization: 10,583 4. Dates Incurred: 1995

Nature of Costs: Loan Costs=\$10,129; Alloc. Itex/A.K. Care = \$454

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>			\$ <u>855,000</u>	1
2					2
3	TOTALS			\$ 855,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1978	750		20	-		750		9
10	Various		1979	12,807		20	201	201	12,473		10
11	Various		1980	35,915		20	-		35,915		11
12	Various		1981	13,910		20	-		13,910		12
13	Various		1982	8,814		20	-		8,814		13
14	Various		1983	12,936		20	-		12,936		14
15	Various		1984	20,560		20	-		20,560		15
16	Various		1985	18,883		20	96	96	18,733		16
17	Various		1986	2,456		20	103	103	2,136		17
18	Various		1987	4,000		20	127	127	1,956		18
19	Various		1988	82,596		20	2,621	2,621	37,274		19
20	Various		1989	1,225		20	39	39	522		20
21	Various		1990	91,597		20	3,783	3,783	41,247		21
22	Various		1993	53,620		20	2,681	2,681	28,518		22
23	Various		1995	137,959		20	7,064	7,064	52,012		23
24	Various		1996	538,107		20	26,907	26,907	190,076		24
25	Various		1997	76,548		20	3,910	3,910	21,814		25
26	Various		1998	77,488		20	3,875	3,875	17,491		26
27							-		-		27
28							-		-		28
29							-		-		29
30							-		-		30
31							-		-		31
32							-		-		32
33							-		-		33
34							-		-		34
35							-		-		35
36							-		-		36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		8,590,563	218,895		55,171	(163,724)	141,395	68
69	Financial Statement Depreciation			33,644			(33,644)		69
70	TOTAL (lines 4 thru 69)		\$ 9,780,734	\$ 252,539		\$ 106,578	\$ (145,961)	\$ 658,532	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,002,533	\$ 252,539		\$ 117,736	\$ (134,803)	\$ 698,031	1
2	STEAMER	1999	705		20	35	35	120	2
3	CHILLERS	1999	993		20	50	50	175	3
4	SMOKE DETECTOR	1999	726		20	36	36	138	4
5	COOLER	1999	602		20	30	30	105	5
6	HOSES	1999	524		20	26	26	91	6
7	DRAIN LINES	1999	1,400		20	70	70	245	7
8	WIRING	1999	1,344		20	67	67	212	8
9	CARPET	1999	10,811		20	541	541	2,613	9
10	ELECTRICAL FIXTURE	1999	563		20	28	28	149	10
11	WINDOW TREATMENTS	1999	1,864		20	93	93	419	11
12	WALLCOVERING	1999	2,473		20	124	124	516	12
13	FLOURESCENT FIXTURES	1999	2,756		20	138	138	575	13
14	CARPET	1999	1,605		20	80	80	348	14
15	WALL COVERINGS	1999	600		20	30	30	150	15
16	FLOURESCENT FIXTURES	1999	2,253		20	113	113	470	16
17	CUSTOM NURSING STATI	1999	6,700		20	335	335	1,619	17
18	WALLCOVERINGS	1999	20,218		20	1,011	1,011	5,392	18
19	WALLCOVERINGS	1999	636		20	32	32	171	19
20	ROOF REPAIRS	2000	7,143		20	183	183	519	20
21	HEAT EXCHANGER	2000	1,942		20	97	97	291	21
22	FLORESCENT FIXTURES	2000	2,014		20	101	101	303	22
23	FLOURESCENT FIXTURES	2000	1,488		20	74	74	222	23
24	FLOURESCENT FIXTURES	2000	2,911		20	146	146	426	24
25	FLOURESCENT FIXTURES	2000	3,307		20	165	165	481	25
26	WALLCOVERING	2000	1,352		20	68	68	193	26
27	WALLCOVERING	2000	1,415		20	71	71	201	27
28	TILE	2000	1,981		20	99	99	272	28
29	TILE	2000	760		20	38	38	105	29
30	SPRINKLER HEAD	2000	878		20	44	44	110	30
31	A/C REPAIRS	2000	12,021		20	601	601	1,452	31
32	FLOURESCENT FIXTURES	2000	494		20	25	25	54	32
33	ELEVATOR REPAIR	2000	1,393		20	70	70	187	33
34	TOTAL (lines 1 thru 33)		\$ 10,098,405	\$ 252,539		\$ 122,357	\$ (130,182)	\$ 716,355	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,098,405	\$ 252,539		\$ 122,357	\$ (130,182)	\$ 716,355	1
2	SPRINKLER SYSTEM	2000	1,000		20	50	50	146	2
3	SPRINKLER RINGS	2000	564		20	28	28	75	3
4	SWITCHES	2000	525		20	26	26	63	4
5	FREEZER	2000	571		20	29	29	68	5
6	PUMP	2000	521		20	26	26	59	6
7	BOILER	2000	1,150		20	58	58	131	7
8	SPRINKLER RINGS	2000	1,316		20	66	66	171	8
9	EXTERIOR INSULATION	2000	511		20	26	26	63	9
10	TMX AND LMX CARDS	2000	1,519		20	76	76	228	10
11	MODEM HOOKUP	2000	1,617		20	81	81	230	11
12	VOICEMAIL INSTALL	2001	1,229		20	123	123	154	12
13	ELECTRICAL WORK	2001	696		20	35	35	44	13
14	BOILERS	2001	56,500		20	2,825	2,825	3,296	14
15	PAGING SYSTEM	2001	25,443		20	1,272	1,272	1,908	15
16	WALLCOVERINGS	2001	754		20	38	38	70	16
17	LIGHT FIXTURES	2001	522		20	26	26	37	17
18	ELEVATOR FLOORING	2001	597		20	30	30	58	18
19	ELEVATOR FLOORING	2001	784		20	39	39	75	19
20	PAINTING	2001	3,779		20	189	189	284	20
21	BOOSTER POWER SUPPLY	2001	876		20	44	44	55	21
22	AC Repair	2001	2,397		20	120	120	200	22
23	SPRINKLER REPAIR	2001	1,014		20	51	51	85	23
24	HANDRAIL	2001	600		20	30	30	45	24
25	HOT WATER VALVE REPA	2001	850		20	43	43	61	25
26	HOT WATER VALVE REPA	2001	1,419		20	71	71	89	26
27	CARPETING	2002	4,550		20	217	217	217	27
28	BORDER PATIENT'S ROOM	2002	1,173		20	293	293	293	28
29	PAINT	2002	713		20	53	53	53	29
30	SINK	2002	642		20	21	21	21	30
31	PAINT	2002	532		20	13	13	13	31
32	COPPER DRAIN	2002	1,400		20	140	140	140	32
33	ROOF REPAIR	2002	974		20	65	65	65	33
34	TOTAL (lines 1 thru 33)		\$ 10,215,143	\$ 252,539		\$ 128,561	\$ (123,978)	\$ 724,852	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,215,143	\$ 252,539		\$ 128,561	\$ (123,978)	\$ 724,852	1
2	ELECTRICAL WORK	2002	1,100		20	46	46	46	2
3	ELECTRICAL WORK	2002	990		20	33	33	33	3
4	FIXTURES	2002	705		20	6	6	6	4
5	EXPANSION COUPLER	2002	1,405		20	141	141	141	5
6	ELECTRICAL AND FIXTURES	2002	590		20	59	59	59	6
7	CABLE LINES	2002	528		20	40	40	40	7
8	CHILLER	2002	2,932		20	171	171	171	8
9	CHILLER	2002	1,697		20	85	85	85	9
10	FLOW SWITCHES	2002	1,185		20	49	49	49	10
11	CARRIER UNIT	2002	759		20	25	25	25	11
12	TWLEPHONE LINES	2002	585		20	20	20	20	12
13	AIR CONDITION REPAIR	2002	1,731		20	43	43	43	13
14	BOILER AND PUMP	2002	1,089		20	18	18	18	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,230,439	\$ 252,539		\$ 129,297	\$ (123,242)	\$ 725,588	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1994		\$ 7,334,294	\$ 205,101	35	\$ 10,830	\$ (205,101)		4
5			1993		379,069	9,720	35	10,830	1,110	103,792	5
6											6
7											7
8											8
	Improvement Type**										
9	HALSTED ASSOCIATES			1994	791,085	2,443	20	40,036	37,593		9
10	ITEX/A.K. CARE			1993	47,698	576	20	2,385	1,809	23,148	10
11	ITEX/A.K. CARE			1994	25,620	666	20	1,281	615	10,608	11
12	ITEX/A.K. CARE			1995	4,366	158	20	218	(60)	1,571	12
13	ITEX/A.K. CARE			1996	247	21	20	12	(9)	87	13
14	ITEX/A.K. CARE			1997	7,366	189	20	368	179	2,025	14
15	ITEX/A.K. CARE			1999	818	21	20	41	20	164	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total  
SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,590,563	\$ 218,895		\$ 55,171	\$ (163,844)	\$ 141,395	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,600,947	\$ 49,551	\$ 158,144	\$ 108,593	10	\$ 1,078,643	71
72	Current Year Purchases	20,583	9,670	2,362	(7,308)	10	2,362	72
73	Fully Depreciated Assets	626,424				10	626,422	73
74								74
75	TOTALS	\$ 2,247,954	\$ 59,221	\$ 160,506	\$ 101,285		\$ 1,707,427	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		AUTO LEXUS	2001	\$ 25,000	\$ 4,900	\$ 3,583	\$ (1,317)	5	\$ 4,777	76
77										77
78										78
79										79
80	TOTALS			\$ 25,000	\$ 4,900	\$ 3,583	\$ (1,317)		\$ 4,777	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,358,393	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 316,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 293,386	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,274)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,437,792	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AUTO LEXUS - 2001	\$ 41,173	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 41,173	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES
- ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Storage				2,643			6
7	TOTAL				\$ 2,643			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 
- 

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 19,422
- Description: Water Cooler-\$1,654; Postage Meter-\$506; Carbon Filters-\$1,245; Copy Machine-\$10,715; ITEX-\$5,302
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:  
Beginning  
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending
- Annual Rent
12. /2003 \$
13. /2004 \$
14. /2005 \$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 60,036		\$	\$		\$ 60,036	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			7,571			7,571	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	63,876					63,876	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				118,552		118,552	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						37,129		37,129	13
14	TOTAL			\$ 123,912		\$ 7,571	\$ 155,681		\$ 287,164	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,000	\$ 391,589	1
2	Cash-Patient Deposits	146,210	146,210	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,893,797	1,893,797	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	262,856	273,019	6
7	Other Prepaid Expenses	18,880	18,880	7
8	Accounts Receivable (owners or related parties)	600,404	600,404	8
9	Other(specify): See Supplemental Schedule	14,550	720,953	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,937,697	\$ 4,044,852	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		855,000	13
14	Buildings, at Historical Cost		7,998,898	14
15	Leasehold Improvements, at Historical Cost	1,307,702	1,307,702	15
16	Equipment, at Historical Cost	1,641,734	2,582,272	16
17	Accumulated Depreciation (book methods)	(1,879,971)	(4,616,100)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		264,184	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	511,275	511,275	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,580,740	\$ 8,903,231	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,518,437	\$ 12,948,083	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 873,737	\$ 1,098,507	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	149,775	149,775	28
29	Short-Term Notes Payable	2,745,291	2,745,291	29
30	Accrued Salaries Payable	247,874	247,874	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,027	33,027	31
32	Accrued Real Estate Taxes(Sch.IX-B)		276,544	32
33	Accrued Interest Payable			33
34	Deferred Compensation	70,000	70,000	34
35	Federal and State Income Taxes		2,689	35
	<b>Other Current Liabilities(specify):</b>			
36	See Supplemental Schedule	501,890	501,890	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,621,594	\$ 5,125,597	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	35,458	35,458	39
40	Mortgage Payable		8,110,016	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Supplemental Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 35,458	\$ 8,145,474	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,657,052	\$ 13,271,071	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (138,615)	\$ (322,988)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,518,437	\$ 12,948,083	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (859,892)	1
2	Restatements (describe):		2
3	ROUNDING ADJUSTMENT	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (859,890)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	721,275	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 721,275	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (138,615)	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 11,819,700	1
2	Discounts and Allowances for all Levels	(631,561)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,188,139	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	692,716	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 692,716	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	738	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	23	15
16	Rental of Facility Space		16
17	Sale of Drugs	213,409	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,594	19
20	Radiology and X-Ray		20
21	Other Medical Services	69,555	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 286,319	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	26,353	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 26,353	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	672	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 672	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,194,199	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,649,097	31
32	Health Care	4,208,633	32
33	General Administration	3,427,444	33
	<b>B. Capital Expense</b>		
34	Ownership	1,611,453	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	412,047	35
36	Provider Participation Fee	164,250	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,472,924	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	721,275	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 721,275	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number HALSTED TERRACE NSG CTR INC.

# 0020842

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,936	2,080	\$ 74,152	\$ 35.65	1
2	Assistant Director of Nursing	1,904	2,112	59,342	28.10	2
3	Registered Nurses	22,656	25,041	553,077	22.09	3
4	Licensed Practical Nurses	65,147	70,322	1,336,070	19.00	4
5	Nurse Aides & Orderlies	143,920	154,657	1,312,684	8.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,360	8,316	123,912	14.90	7
8	Rehab/Therapy Aides	8,302	9,150	136,190	14.88	8
9	Activity Director	1,936	2,080	23,159	11.13	9
10	Activity Assistants	18,772	20,426	157,625	7.72	10
11	Social Service Workers	10,793	11,858	148,885	12.56	11
12	Dietician					12
13	Food Service Supervisor	1,672	2,080	24,838	11.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,867	34,307	248,255	7.24	15
16	Dishwashers					16
17	Maintenance Workers	5,976	6,651	88,880	13.36	17
18	Housekeepers	34,413	36,821	298,803	8.12	18
19	Laundry	11,943	12,847	67,106	5.22	19
20	Administrator	2,000	2,080	88,757	42.67	20
21	Assistant Administrator	1,902	2,088	30,466	14.59	21
22	Other Administrative	2,912	2,912	353,784	121.49	22
23	Office Manager					23
24	Clerical	7,956	8,735	192,292	22.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,759	2,056	27,105	13.18	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	6,782	7,412	124,116	16.75	33
34	TOTAL (lines 1 - 33)	391,908	424,032	\$ 5,469,498 *	\$ 12.90	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	360	\$ 11,620	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	Fee	7,600	10-03	38
39	Pharmacist Consultant	Monthly	5,928	10-03	39
40	Physical Therapy Consultant	4	220	10a-03	40
41	Occupational Therapy Consultant	3	237	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,400	11-03	44
45	Social Service Consultant	81	4,428	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	448	\$ 60,561		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Joelynn Miller-Johnson	Administrator	0	\$88,757
Mark Hollander	Executive	0	171,057
Bernard Hollander	Administrative	83.33%	182,727
Yolanda Jackson	Asst. Admin	0	30,466
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			\$473,007
B. Administrative - Other			
Description			Amount
Management Fees - JLR Management		\$	180,000
Management Fees - Shaymark			305,500
Management Fees - Bernard Cohen & Associates			60,000
Network Fees - CarePath			63,432
TOTAL (agree to Schedule V, line 17, col. 3)		\$	608,932
(Attach a copy of any management service agreement)			
C. Professional Services			
Vendor/Payee	Type		Amount
A.K. Care	Bookkeeping	\$	440,400
FR&R	Accounting		37,783
Susan Lewis	Accounting		14,940
GE Information	Data Processing		4,665
Power Software	Computer Consulting		7,014
Horizon Healthcare	Computer Consulting		4,253
Health Care Horizons	Administrative Consulting		4,800
Personnel Planners	Unemployment Consulting		2,427
See Attached	Legal		58,199
	Joint Commission Consult		3,495
TOTAL (agree to Schedule V, line 19, column 3)			
(If total legal fees exceed \$2500 attach copy of invoices.)		\$	577,977
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	65,294
Unemployment Compensation Insurance			58,514
FICA Taxes			404,275
Employee Health Insurance			227,002
Employee Meals			31,317
Illinois Municipal Retirement Fund (IMRF)*			
Head Tax			11,195
Christmas Expense			6,024
Pension/Savings Plan			36,659
TOTAL (agree to Schedule V,		\$	840,280
line 22, col.8)			
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	200
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 649 )			6,816
Public Relations/Yellow Page			122,479
Licenses & Fees			1,150
Dues & Subscriptions			722
Alloc.-ITEX/Carepath			6,447
IL Council on LTC- Dues			11,254
Classified Advertising			6,132
Less: Public Relations Expense			(119,524)
Non-allowable advertising		(	)
Yellow page advertising			(2,955)
TOTAL (agree to Sch. V,		\$	32,721
line 20, col. 8)			
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			4,782
Allocation ITEX/Carepath			100
Non-allowable			(1,033)
Entertainment Expense		(	)
(agree to Sch. V,			
TOTAL		\$	3,849
line 24, col. 8)			

**\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		HALSTED TERRACE NSG CTR INC.		STATE OF ILLINOIS				Page 23
		#	0020842	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount.

Yes  
ICLTC-\$16,740.00

(3)

Did the nursing home make political contributions or payments to a political action organization?  
If YES, have these costs been properly adjusted out of the cost report?

Yes  
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period?

Yes  
10 Yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 90,548 Line 10-02

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?  
If YES, give effective date of lease.

No

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X  
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.  
This amount is to be recorded on line 42 of Schedule V.

\$ 164,250

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  
If YES, attach an explanation of the allocation.

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?  
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)  
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.  
Has any meal income been offset against related costs?

\$ 31,317  
N/A  
Indicate the amount. \$

(16)

Travel and Transportation  
a. Are there costs included for out-of-state travel?  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents?  
If YES, please indicate the amount of income earned from such a program during this reporting period.  
c. What percent of all travel expense relates to transportation of nurses and patients?  
d. Have vehicle usage logs been maintained?  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No  
No  
100% In 14  
No  
N/A  
N/A

g. Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.

N/A  
\$

(17)

Has an audit been performed by an independent certified public accounting firm?  
Firm Name:  
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?  
If no, please explain.

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  
Attach invoices and a summary of services for all architect and appraisal fees

Yes

SEE ACCOUNTANTS' COMPILATION REPORT